

**Evidence-  
and  
Rights-Based  
Planning & Support Tool  
for  
SRHR/ HIV-Prevention  
Interventions  
For Young People**

**STOP AIDS NOW!**  
*In collaboration with*  
**World Population Foundation &  
Maastricht University**

**The Netherlands, July 2008**

## Colophon

*The Netherlands, July 2008*  
Second version

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## PREFACE

The idea for this planning and support tool was initiated by a number of organisations in the Netherlands working on the theme of orphans and vulnerable children (OVC). They and their partner organisations in developing countries had identified the need to use available evidence and theory when planning SRHR education programs for young people.

The first version was developed of the tool with help of Maastricht University, primarily based on the evidence provided by Kirby, integrated in the Intervention Mapping model.

The tool was tested out in workshops in South Africa and Pakistan with partner organisations who implement SRHR interventions for young people (either school based or out of school). It was decided to test out the tool in a setting with high HIV-prevalence and in a setting with low HIV-prevalence. Other criteria were to test the tool both in African and Asian setting.

After testing out the tool, the second version of the tool was designed. Some of the major conclusions after using it in South Africa and Pakistan include:

- The tool is very useful in initiating discussions in the own organisations that apply the tool. It adds to systematic planning and provides an overview of the most important aspects in SRHR education planning.
- The tool also turns out to be useful for linking and learning between organisations. By going through the whole tool step by step and exchanging experiences for each indicator, this initiates sharing and learning from each other.
- The tool is useful for planning on intervention level, but also on strategic planning level.
- It is difficult for most organisations and participants to link the IM model that is underlying the tool with the way they usually work through Logical Framework Approaches and project planning models. To a certain extent the approaches overlap, but there are also differences in approach and way of working. E.g., both models emphasise stakeholder involvement, needs assessment, systematic and logic (causal) planning. But generally project planning models are more comprehensive (not only focusing on the intervention itself, working with the target groups, but also on funding, organisational strengthening aspects). IM does not take that into account and focuses only on the intervention itself.
- The language used in the tool is sometimes too academic and should be made more practical.
- Organisations are very much concerned to get funding for their interventions. They therefore argued that donor organisations should also become familiar with the tool.
- Organisations of both countries argued that the tool should not only focus on interventions in schools, but also on programs that are implemented outside the school setting.
- It would be useful to provide a separate annex for each specific country with specific evidence of what works and does not work in the particular country or context.
- Guidelines should be added on how the tool can be used. Feedback showed that when the tool is not introduced in a correct way, it can result in a lot of uncertainty and the feeling to be evaluated and compared to other organisations.

Most of the comments and feedback were included in this tool. We want to thank the organisations in South Africa, Pakistan and the Netherlands that provided very useful and detailed comments. Organisations in South Africa: D4Life, Targeted Aids Intervention, Catholic Institute of Education, South African Scouts Association, Stellenbosch University, God's Golden Acre; in Pakistan: AAHUNG, IHDCS, AMAN Foundation, AAS, PAVNHA, PNAC, DANESH, WPF Pakistan; and in the Netherlands: Save the Children Netherlands and the SAN! partners Cordaid, Oxfam/Novib, ICCO

The tool is a supplement to the IM Toolkit for Planning Sexuality Education Programs.<sup>1</sup> SAN! and WPF support any effort in applying and spreading this tool and appreciates any comment and feedback for improvement.

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## ABBREVIATIONS

<b>AB</b>	Advisory Board
<b>BCC</b>	Behaviour Change Communication
<b>CBO</b>	Community Based Organisation
<b>FGD</b>	Focus Group Discussion
<b>FPA</b>	Family Planning Association
<b>GO</b>	Governmental Organisation
<b>HPB</b>	Health Promoting Behaviour
<b>ICPD</b>	International Conference on Population and Development
<b>IDI</b>	In Depth Interview
<b>IEC</b>	Information, Education and Communication
<b>IPPF</b>	International Planned Parenthood Federation
<b>IM</b>	Intervention Mapping
<b>NGO</b>	Non-Governmental Organisation
<b>OVC</b>	Orphans and Vulnerable Children
<b>PCM</b>	Project Cycle Management
<b>PLWHA</b>	People Living With HIV/AIDS
<b>PO</b>	Performance Objective
<b>RTI</b>	Reproductive Tract Infection
<b>SAN!</b>	STOP AIDS NOW!
<b>SATZ</b>	South Africa - Tanzania
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>STI</b>	Sexually Transmitted Infection
<b>UM</b>	Maastricht University
<b>UN</b>	United Nations
<b>WG</b>	Working Group
<b>WHO</b>	World Health Organisation
<b>WPF</b>	World Population Foundation
<b>YFC</b>	Youth Friendly Centre

## INTRODUCTION

More than half of the global population consists of young people. Many of them face HIV/AIDS, STIs, teenage pregnancies, gender inequality, discrimination and other (health) challenges, particularly in developing countries. Organisations worldwide have designed interventions to address these problems related to young people's sexual and reproductive health and rights (SRHR). Some aim at the prevention of SRHR problems, others on care of people facing these problems and others aim at lobby and advocacy to change policies or legislation.

The interventions vary with regard to target groups, implementation settings and scope. Examples of interventions that aim at prevention include Life Skills programs, HIV prevention programs, Sexuality education, and Information, Education and Communication (IEC). In this tool we refer to these programs as 'SRHR education interventions'.

Implementing organisations aim to improve young people's quality of life and health, and therefore aim to implement interventions that are effective and are of good quality. But developing effective interventions is not easy. Worldwide, extensive experience, evidence and information is available showing what works and what not. This tool attempts to document the most important evidence, in a way that is useful for organisations with limited time and resources, working in the day to day practice of SRHR education for young people.

The tool provides a 'blueprint' of how organisations can most optimally design and evaluate SRHR education programs for young people in a school setting and outside the school setting, such as street children, working children. The tool can be used to optimise the design and implementation of new programs, but can also be used to analyse existing interventions.

## DEFINITIONS

In this tool, we use the following definitions related to project, program, and intervention. In the context of development cooperation, a project has a definite start and definite end where as programs are usually on going and adapted according to the need. A *program* often consists of a cluster of projects, for example, all projects in a particular country (country program), or focusing on a particular issue (AIDS program). One *project* generally aims to achieve one purpose (e.g., behaviour change of young people), and includes both the design of a intervention program, and the management actions to be able to achieve that.

An *intervention* can be defined as the whole package of activities and associated/ supportive materials to be offered to the beneficiaries (young people) and relevant people around them, such as teachers, parents, community, and health care providers. In this tool, the intervention consists at one hand of activities and associated/ supportive materials that are designed to influence sexual behaviour of young people, by providing them with information, skills training, and attitude clarification, and by empowering them to take their own decisions. And at the other hand the intervention consists of all activities and associated/ supportive materials that are designed to influence young people's environment including the implementers of the intervention and for instance parents.

## APPROACHES

This tool is based on two major approaches: a theory- and evidence based approach and a rights-based approach.

### 1. Theory and Evidence-Based Approach

The tool is based on what is already known about effective interventions. Researchers, planners and implementers all over the world have gained a lot of experience and documented lessons learned while designing and implementing school-based SRHR education programs. We have tried to select the most important information (evidence and theories) for this tool. An important source is a review of effective interventions worldwide, done by Kirby and his colleagues.<sup>2,3</sup> A model that emphasises the use of evidence and theory is the Intervention Mapping model.<sup>4</sup> We have used this model to structure the available information in this tool.

#### *Intervention Mapping*

The *Intervention Mapping model* supports planners to systematically design health programs and encourages them to take evidence-based decisions. One of the assumptions of the model is that by using theory and evidence in planning interventions, these are more likely to be effective in creating change among target groups. In this tool we use the following 6 steps, based on the original model:

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

These steps differ from the original model. The original model also consists of 6 steps, but does not include involvement as a separate step, and has separated the ‘evidence-based’ and ‘intervention design’ into two separate steps. The steps are also used in a manual about the use of Intervention Mapping in designing SRHR education programs. We will refer to the various chapters of the manual when applicable.

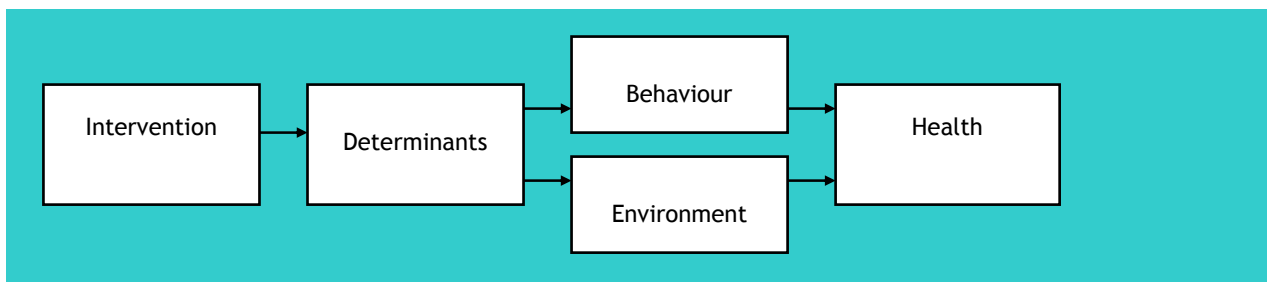
#### *PRECEDE-model*

One of the theories that is used in Intervention Mapping is the PRECEDE-model.<sup>5</sup> This model has as starting point the health problem that needs to be reduced, for example, HIV/AIDS. We want to know why these problems are there and then we may come up with many reasons: because of unsafe blood transfusions, because people are not aware of HIV/AIDS, because they have sexual intercourse without using a condom, or because young people are influenced by their peers. PRECEDE has divided all these reasons (or factors) in different categories: behaviour, environment and determinants.

The advantage of using such a model is that planners are more likely to think of all factors that are relevant in explaining and changing a health problem. The model can help to identify factors on different levels, and how these factors are (causally) related. When planners have a clear idea about ‘the problem’ and the factors that determine the problem, they can address these in the intervention, and are more likely to create change.

## Behaviour and environment

We first look at behaviour and environment. Behaviour is the behaviour of the person who gets infected with HIV/AIDS. For example, someone has sexual intercourse without a condom. Environment means everything that happens outside the control of the person who gets infected. For example, the unsafe blood transfusion. Other environmental factors may include social or cultural norms in the community; availability and affordability of health care (testing facilities) and supplies (e.g., condoms), and availability of information. The model below shows that health is influenced by behaviour and by environment.

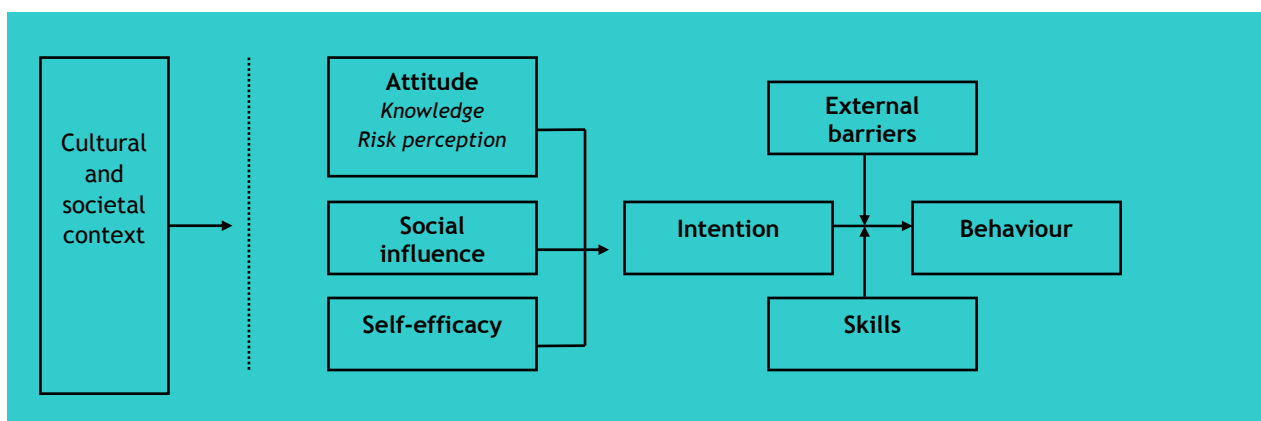


## Determinants

In the list of reasons above, we also mentioned that people may not be aware of HIV/AIDS and that young people may be influenced by their peers. In PRECEDE, these are called determinants of behaviour. So when we look at the behaviour of people who do not use condoms, we can identify the factors that influence this behaviour. So indirectly, through the behaviour, determinants influence people's health (e.g., HIV/AIDS).

There are various theories that can be used to look at the determinants of behaviour. One of them is the Theory of Planned Behaviour, which is often applied in explaining sexual behaviour. This model is combined with some other models and provides a framework of determinants that are relevant in SRHR interventions for young people.<sup>6</sup> Determinants can be divided into two categories: *internal* determinants (within their own 'control') and *external* determinants (outside their own 'control', influences or obstacles in their (social) environment).

- Internal determinants of behaviour
  - *Knowledge* and misconceptions about sexuality, HIV, STIs, pregnancy, methods of prevention, unsafe abortion, early motherhood, rights, stigma
  - *Risk perception* with regard to the aforementioned health-related problems
  - *Personal values* and beliefs about sex and abstinence, discrimination and stigma, rights
  - *Attitudes* towards condom use, including barriers to use condoms
  - *Perception of peer norms* and peer behaviour related to sex
  - *Perception of social norms* in community and support related to health promoting behaviour
  - Skills & self-efficacy to negotiate sexual intercourse and use condoms, to avoid places and situations that might lead to unsafe and/or unwanted sex
- External determinants of behaviour
  - *Norms* of peers related to sexuality
  - *Social norms* in community
  - *Communication* with parents/ other adults about condoms, sex, contraception, gender, discrimination and stigma
  - Laws/ legislation
  - Availability/ affordability of supplies
  - Other external barriers



Determinants of environmental conditions can also be explained in terms of behaviour of the people or organisations that need to provide the conditions. For example, the reasons (knowledge, attitudes) for health care providers (not) to provide condoms to young people.

### Intervention

When planners are aware of the most important determinants/factors that influence behaviour and the environment, then they can develop activities and materials in the intervention to address these. For example, they can develop a skills training to train communication skills. Or organise group discussions to make youth aware of their own values and how they are influenced by others. When the causal relations between determinants, behaviour and environment are clear, planners can expect that by changing the determinants, this will ultimately result in change in behaviour and environment.

### Theory

When we talk about theory in this tool, we point at various theories that have proven to be useful and effective in explaining behaviour and factors that determine health problems; but also at theories that give suggestions for changing behaviour at its determinants in an effective way.

For example, one of the most known theories on behaviour change is the Social Cognitive Theory of Bandura. Bandura provides a number of suggestions how communication will have an impact on people, or how people will gain skills in the most optimal way. When planners apply these principles, the interventions are more likely to actually change something.<sup>7;8</sup>

Another example is that theory suggests that fear-based interventions do not change people's health behaviour, but may even have an opposite effect. The same theories suggest that people will only change their behaviour, when they also have the confidence that they can do something about it. A number of researchers have summarised some of the most relevant theories on behaviour change and explained it in a practical way.<sup>8</sup>

Several reviews of sexuality education and AIDS prevention programs conclude that social cognitive theories, particularly cognitive behavioural theories, can add understanding about explanation and change of sexual behaviour and its behavioural determinants.<sup>2</sup>

Research also shows that particular theories are useful in understanding the factors that influence people's sexual behaviour, and other theories are found to be useful in changing sexual behaviour.

### Evidence

With evidence we mean all information that either supports or contradicts the decisions that are taken in planning interventions. This information can be based on the experience of a planner in other projects, sometimes not even documented. But because of working in a field for some time, people get to know what works and what does not. This is what we call evidence. And even though this evidence may be very trustworthy, stronger evidence can be found in documentation of

research. Either in reports or in publications such as articles. And of course, the more studies find similar information, it is more likely to be 'true'. Therefore, we see reviews which meet particular criteria, as for example was done by Kirby and colleagues, as very strong evidence.

Most guidelines for qualifying evidence use 4 or 5 levels of evidence, which are also used in this tool to make distinctions between categories of evidence.<sup>9;10</sup>

Level	Kind of evidence
1	Meta-analysis, systematic review
2	Quantitative studies, randomisation, control & intervention groups, pre- and post test
3	Non-analytical studies, e.g. case report, case series
4	Opinions of experts

Evidence can be collected during a baseline or needs assessment/ situation analysis. It can be retrieved from publications in scientific journals, reports, interviews with experts, good practices, reports and other documents. The Internet also is a rich resource to get information, including websites such as [scholar.google.com](http://scholar.google.com) that provide links to (scientific) publications, and thematic organisations such as World Health Organisation or UNAIDS.

Sometimes there is contradicting evidence for particular events or issues. It may be tempting to find evidence that supports an organisation's practices or approach, but this does not always mean that this is resulting in increased effectiveness. In this tool we have tried to be as 'objective' as possible. Another remark is that evidence that applies to one setting does not necessarily apply to other settings as well. It is therefore wise to use evidence, but check whether it is applicable in the particular setting as well.

## 2. Rights-Based Approach

The tool is also based on a human rights approach. In the context of SRHR education for young people, this approach refers to their sexual and reproductive rights to take their own decisions and to being supported by people, policies and organisations their environment to do that. These rights are laid down in a number of international conventions and conferences, signed by almost all countries in the world.

Generally, sexual and reproductive rights of young people are described as:<sup>11</sup>

- Right to be yourself: free to make your own decision, to express yourself, to enjoy sex, to be safe, to choose to marry (or not to marry) and plan a family
- Right to know: about sex, contraceptives, STIs, HIV/AIDS and reproductive and sexual rights
- Right to protect oneself and be protected by others: from unplanned pregnancies, STIs, HIV/AIDS and sexual abuse
- Right to have access to health services: which is confidential, affordable, good quality and given due respect
- Right to be involved: in planning programs with and for youth, attending meetings/seminars etc. at all levels and trying to influence governments through appropriate means

## USING THE TOOL

### Who can use the tool?

The tool is developed for organisations who plan to design or are already implementing interventions. Usually, a team of researchers and intervention developers designs the interventions. In this tool we refer to them as the *intervention planners*.

*Program or project managers* are defined as the desk officers of donor organisations and implementing organisations who manage the project and have to decide about funding based on project proposals. In many implementing organisations the project managers are the same as the intervention planners, depending on the type, context and size of the organisation.

The person who will use the tool should be involved in or informed of the planning (design, implementation, evaluation) of the intervention. Otherwise incorrect information may be provided. The tool can be used by people or organization itself, without any guidance or interaction. But it can also be used with a group of organizations or people.

### Aim of the tool

The aim of the tool is to encourage intervention planners and project planners to think about the reasons why the intervention and the implementation are the way it is. For example, why does an intervention only pay attention to giving information and not to values and attitudes? Or why is an intervention delivered by peer educators and not, for instance, by teachers? The tool supports planners to take well-informed decisions about the planning, development, implementation and evaluation of interventions.

The aim of the tool is rather to facilitate planners to look at the intervention than a tool to assess critically and give judgements on that. The tool can be used to analyse or plan a variety of SRHR interventions: large and small; with a focus on HIV, STIs, and/or pregnancy, or a comprehensive approach; targeting older or young people; orphans and vulnerable children (OVC) and/or other young people; in-school and non-school-based interventions.

This tool focuses on criteria of interventions that work. Planners can use it to look at their existing programs, but can also use the criteria when they plan new interventions.

Looking at it from another perspective, the tool has also proven to be useful in other purposes. For example, as a framework to guide discussion between a donor agency and an implementing organisations; for capacity building and improvement of the own organisation and own program; to take the opportunity to document the intervention planning afterwards. And is a useful tool for linking and learning between different organisations, as we did in South Africa and Pakistan, where a number of organisations working with young people and AIDS/ SRHR education used the criteria in the tool to exchange experiences and lessons learned. This however requires a safe setting to avoid feelings of evaluation and competition.

### Existing and new interventions

Planners can use the tool for monitoring and evaluation of *existing interventions*. This can contribute to the identification of what is effective, and where the gaps are. No intervention is perfect and depend on a large number of factors, such as available resources and limitations in the implementation setting.

The analysis shows which gaps may occur and may need improvement, but it may not be possible to address all the gaps. Planners decide what is most important and most changeable, also in terms of available resources and capacity. For example, interventions that have been pre-tested are generally more effective. When the analysis shows that the intervention is not pre-tested, the next step may be to start pre-testing all future interventions. Planners may decide to address the issues

themselves or to collaborate with other organisations that already have particular experience and are able to address it.

The tool can also be used when planners design *new interventions*. It provides a framework of how SRHR programs can be designed, implemented and evaluated. However, the tool should not oblige organisations to implement programs completely according to the tool indicators. Of course the particular context or implementation setting or mandate of an organisation makes it necessary for certain choices that are not following the tool.

Planning new interventions according a systematic, theory- and evidence-based approach usually takes more time. It is sometimes difficult for implementing organisations to find resources (time and funding) to plan interventions in such a way. Another obstacle can be to ‘translate’ the Intervention Mapping terminology into the format and requirements of various donor agencies, each having their own terminology and requirements. And another remark of implementing organisations is that few donors listen to them, they have to implement the agendas and interest of the donor agencies.

## CONTENTS OF THE TOOL

This document starts with an overview of the characteristics related to what intervention planners can do to improve the process of intervention development and the content of interventions itself. For each of the characteristics, Annex 1 provides explanation and global evidence. References to more extensive background information about each of the characteristics are provided. The evidence describes the do’s and don’ts related to development, implementation and evaluation of SRHR education programs. The reference can be found at the end of the document (in References) where the number shows which evidence was used.

The tool consists of a number of columns:

- *Characteristic*; the characteristics of ‘interventions that work’
- *Indicators* for each of the characteristics
  - What was done or included in the intervention and what not?
  - What was its quality, or how was it included?
- *Conclusion* about the quality of the characteristic, this can be done for both the ‘what’ and the ‘how’, and for the different sub-indicators mentioned
  - ++      *excellent*
  - +        *fair*
  - *needs improvement*
  - *is not done at all*
  - X        *not applicable*
- *Comments* on the analysis and suggestions for improvement

The characteristics are divided into 7 categories:

- A. Approach
- B. Step 1. Involvement
- C. Step 2. Needs Assessment/ Situation Analysis
- D. Step 3. Objectives
- E. Step 4. Evidence-Based Intervention Design
- F. Step 5. Adoption and Implementation
- G. Step 6. Monitoring and Evaluation

## PLANNING AND SUPPORT TOOL

++ *excellent*  
 + *fair*  
 - *needs improvement*  
 -- *is not done at all*  
 X *not applicable*

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
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### A. APPROACH

1. Is the intervention based on a comprehensive approach?	<ul style="list-style-type: none"> <li>Is the intervention based on a rights based approach?               <ul style="list-style-type: none"> <li>Right to be yourself and take own decisions</li> <li>Right to know</li> <li>Right to protect oneself and be protected by others</li> <li>Right to have access to health services</li> <li>Right to be involved</li> </ul> </li> </ul>		How do you value the extent to which this was done?		
	Is gender included in all relevant aspects of planning and content?		Is this done well?		
	Are females and males both involved in intervention design?		Are they well involved?		
	Does the intervention address equal rights of males and females?		Is this well included?		
	Does the organisation have and implement a gender policy?		Is it well implemented?		
	Does the intervention provide information about preventive sexual behaviours of young people?		Is the information non-judgemental, complete?		
	<ul style="list-style-type: none"> <li>Is HIV/AIDS prevention embedded in the broader scope of SRHR education?</li> <li>Adolescent development (physical, emotional, social, sexual)</li> <li>Sexual health problems are embedded in a positive approach</li> </ul>		How do you value the extent to which this was done?		
<ul style="list-style-type: none"> <li>Is the intervention part of creating an enabling environment?               <ul style="list-style-type: none"> <li>Legislation/ policies</li> <li>Health services/ counselling</li> <li>Supplies such as condoms, contraceptives</li> </ul> </li> </ul>		How do you value the extent to which this was done?			
2. Does the intervention explicitly communicate about sexuality?	<ul style="list-style-type: none"> <li>Is the intervention explicit about:               <ul style="list-style-type: none"> <li>sexuality</li> <li>masturbation</li> <li>own decision making</li> <li>naming genitals</li> <li>contraceptives, condoms</li> </ul> </li> </ul>		How do you value the extent to which this was done?		

CHARACTERISTIC	INDICATORS - WHAT	++	INDICATORS - HOW	++	COMMENTS SUGGESTIONS FOR IMPROVEMENT
		+		-	
		--		--	
		X		X	
	<ul style="list-style-type: none"> <li>· Is the communication about sexuality tailored to the target group? <ul style="list-style-type: none"> <li>- age</li> <li>- urban/rural</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value the extent to which this was done?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Are facilitators encouraged and trained to openly communicate with young people about sexuality?</li> </ul>		<ul style="list-style-type: none"> <li>· How do you value the extent to which this was done?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Are young people well approached? <ul style="list-style-type: none"> <li>- Young people are approached as sexual beings</li> <li>- Young people are approached as able to make own decisions</li> <li>- Sexuality is approached in a positive way</li> <li>- Young people are approached as a diverse and heterogeneous group</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value the extent to which this was done?</li> </ul>		

## B. INVOLVEMENT (Step 1)

<b>3. Are the right people involved in the planning team?</b>	<ul style="list-style-type: none"> <li>· Is the following expertise represented in the planning team: <ul style="list-style-type: none"> <li>- Project management</li> <li>- Research</li> <li>- SRHR of young people</li> <li>- Behaviour change theories</li> <li>- Design of SRHR interventions for young people</li> <li>- Implementation of SRHR interventions for young people</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· Are they involved in all relevant planning stages?</li> <li>· Are the values and attitudes of the planning team members according a comprehensive SRHR approach?</li> </ul>		
<b>4. Are young people involved in intervention planning?</b>	<ul style="list-style-type: none"> <li>· Is a working group established with representatives of young people?</li> </ul>		<ul style="list-style-type: none"> <li>· Are the right people part of the working group?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Are they involved during all relevant planning stages: <ul style="list-style-type: none"> <li>- Design of the project plan/ proposal</li> <li>- Respondents in the needs assessment/ situation analysis</li> <li>- Interpretation of conclusions of the needs assessment/ situation analysis and deciding about the objectives</li> <li>- Intervention design (including pre-testing)</li> <li>- Implementation, as peer educators</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· What is the quality of involvement?</li> </ul>		
<b>5. Are facilitators involved in intervention planning?</b>	<ul style="list-style-type: none"> <li>· Is a working group established with representatives of facilitators?</li> </ul>		<ul style="list-style-type: none"> <li>· Are the right people part of the working group?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Are they involved during all relevant planning stages: <ul style="list-style-type: none"> <li>- Design of the project plan/ proposal</li> <li>- Respondents in the needs assessment/ situation analysis</li> <li>- Interpretation of conclusions of the needs assessment/ situation analysis and</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· What is the quality of involvement?</li> </ul>		

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	<ul style="list-style-type: none"> <li>· deciding about the objectives</li> <li>- Intervention design (including pre-testing)</li> <li>- Implementation, as peer educators</li> <li>- Up scaling, as trainers of trainers (ToT)</li> </ul>				
<b>6. Are relevant decision makers involved in intervention planning?</b>	<ul style="list-style-type: none"> <li>· Have you obtained at least minimal support from relevant authorities? <ul style="list-style-type: none"> <li>- Ministry of Education</li> <li>- Ministry of Health</li> <li>- Ministry of Youth</li> </ul> </li> </ul>		· What is the quality of support?		
	<ul style="list-style-type: none"> <li>· Have you obtained support from appropriate organizations or individuals needed to fully implement the intervention? <ul style="list-style-type: none"> <li>- Parents/ community</li> <li>- Community/ religious leaders</li> <li>- In schools: board, school administration</li> </ul> </li> </ul>		· What is the quality of support?		
	<ul style="list-style-type: none"> <li>· Have you involved key stakeholders in SRHR (education)? <ul style="list-style-type: none"> <li>- AIDS commission</li> <li>- Family Planning Association</li> <li>- Funding agencies</li> <li>- Relevant NGOs</li> <li>- Health service providers</li> <li>- Youth based organisations</li> <li>- Community organisations</li> </ul> </li> </ul>		· What is the quality of involvement?		

### C. NEEDS ASSESSMENT/ SITUATION ANALYSIS (Step 2)

<b>7. Is the intervention based on a needs assessment?</b>	· Were all important aspects assessed?		· What is the quality of the assessment?		
	· Overall quality of life of young people		<ul style="list-style-type: none"> <li>· What is the reliability and quality of data?</li> <li>· To what extent are data applicable to your target group?</li> <li>· Were data collected among representatives of the target group?</li> <li>· Were data collected among multiple adults who are</li> </ul>		
	<ul style="list-style-type: none"> <li>· Magnitude of SRHR problems of young people <ul style="list-style-type: none"> <li>- HIV/STI rates</li> <li>- Teenage pregnancy, abortion</li> <li>- Sexual abuse/ harassment</li> </ul> </li> </ul>				
	<ul style="list-style-type: none"> <li>· Sexual behaviours of young people <ul style="list-style-type: none"> <li>- Sexual behaviour/ abstinence</li> <li>- Condom use</li> <li>- Number/ kind of sexual partners</li> </ul> </li> </ul>				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	<ul style="list-style-type: none"> <li>· Internal determinants of behaviour</li> <li>- Knowledge/ misconceptions</li> <li>- Attitude/ values/ beliefs</li> <li>- Risk perception</li> <li>- Skills/ self-esteem/ self-confidence</li> <li>- Solutions for their own problems</li> </ul>		<ul style="list-style-type: none"> <li>involved with youth?</li> <li>· Were the data collected by trained researchers/ assistants?</li> <li>· Were challenges in avoiding sex and using condoms or contraceptives discussed openly?</li> </ul>		
	<ul style="list-style-type: none"> <li>· External determinants of behaviour</li> <li>- Social influence/ norms</li> <li>- Laws/ legislation</li> <li>- Availability/ affordability of supplies</li> <li>- Other external barriers</li> </ul>		<ul style="list-style-type: none"> <li>· Was the methodology of data collection of good quality?</li> <li>· Was the analysis of data done objectively?</li> <li>· Was the reporting of the results done objectively?</li> </ul>		
<b>8. Is the intervention based on a situation analysis?</b>	<ul style="list-style-type: none"> <li>· Were all important aspects assessed?</li> </ul>		<ul style="list-style-type: none"> <li>· What is the quality of the assessment?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Did you collect and analyse relevant laws, policies and regulations and analyse to what extent these are implemented?</li> <li>- Related to young people/ adolescents</li> <li>- Related to SRHR (HIV/AIDS, gender, ...)</li> </ul>		<ul style="list-style-type: none"> <li>· What is the reliability and quality of data?</li> <li>· To what extent are data applicable to your target group?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Did you assess relevant norms and values in the community?</li> <li>- Sexuality, abstinence, marriage</li> <li>- position of girls and boys</li> <li>- HIV/AIDS, pregnancy</li> <li>- communication with young people about sexuality</li> <li>- condoms and other contraceptives</li> <li>- sexual orientation, abortion</li> <li>- right of young people to take their own decisions</li> </ul>		<ul style="list-style-type: none"> <li>· Were data collected among representatives of the target group?</li> <li>· Were data collected among multiple adults who are involved with youth?</li> <li>· Were the data collected by trained researchers/ assistants?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Did you analyse the available resources in the community?</li> <li>- networks of care</li> <li>- (youth friendly) health care, services, counselling</li> <li>- commodities (condoms and other contraceptives)</li> <li>- collaboration/ referral to these organisations</li> </ul>		<ul style="list-style-type: none"> <li>· Were challenges in avoiding sex and using condoms or contraceptives discussed openly?</li> <li>· Was the methodology of data collection of good quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Did you analyse barriers and opportunities in the implementation setting?</li> <li>- In school: school administration and others - knowledge, misconceptions and attitudes</li> <li>- safe and comfortable facility for implementation</li> </ul>		<ul style="list-style-type: none"> <li>· Was the analysis of data done objectively?</li> <li>· Was the reporting of the results</li> </ul>		

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	<ul style="list-style-type: none"> <li>- supplies (e.g., video equipment, pencils)</li> <li>- trained and available facilitators</li> </ul>		done objectively?		
	<ul style="list-style-type: none"> <li>· Did you assess the needs of facilitators?</li> <li>- Behaviour</li> <li>- Internal determinants (knowledge, attitude, skills)</li> <li>- External determinants (materials, time, social support)</li> <li>- What motivates them to do this?</li> </ul>				
	<ul style="list-style-type: none"> <li>· Did you collect and analyse existing SRHR education interventions?</li> <li>- Materials</li> <li>- Lessons learned</li> </ul>				

#### D. OBJECTIVES (Step 3)

<b>9. Are the ultimate health goals of the intervention clearly outlined?</b>	· Are the quality of life goals clearly outlined?		<ul style="list-style-type: none"> <li>· Is it based on evidence?</li> <li>· What is quality of evidence?</li> </ul>		
	· Are the health goals clearly outlined?				
	· Does the intervention reflect these goals?				
<b>10. Are the behavioural messages for young people clear and consistent?</b>	<ul style="list-style-type: none"> <li>· Does the intervention clearly focus on one or more specific behaviours that directly affect pregnancy, STIs/HIV and consensual sex?</li> <li>- Abstinence (from all sexual activities)</li> <li>- Only have consensual sex</li> <li>- Delay sexual intercourse and practice other sexual activities</li> <li>- If you have sexual intercourse, use a condom every time you have sexual intercourse</li> <li>- (Serial) monogamy, including an HIV test</li> <li>- Limit number of sexual partners</li> <li>- HIV and STI testing and treatment</li> </ul>		<ul style="list-style-type: none"> <li>· Is it based on evidence?</li> <li>· What is quality of evidence?</li> </ul>		
	· Are the messages appropriate to the age, sexual experience, family and community values, and culture of the youth for whom the intervention is intended?				
	· Does the intervention link the behavioural messages with other important values among youth?				
	<ul style="list-style-type: none"> <li>· Is it clear what is meant with the behavioural messages?</li> <li>- condom use (buying, carrying, negotiating, ...)</li> </ul>				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	- abstinence from what, up to when, ...				
<b>11. Is it clear what will be done to promote a supportive environment?</b>	<ul style="list-style-type: none"> <li>Do you outline what you promote, influence or change to increase young people's SRHR?</li> <li>Do you identify who has the responsibility to change (services)?</li> </ul>		<ul style="list-style-type: none"> <li>Is it based on evidence?</li> <li>What is quality of evidence?</li> </ul>		
	<ul style="list-style-type: none"> <li>Have you outlined what you will do and with which organisations you will collaborate to create a supportive environment? <ul style="list-style-type: none"> <li>Community awareness</li> <li>Services, counselling</li> <li>Supplies</li> <li>Advocacy</li> </ul> </li> </ul>				
	<ul style="list-style-type: none"> <li>Do you outline the behavioural determinants, such as knowledge, attitudes and skills for the people responsible for changing the environment?</li> </ul>				

#### E. EVIDENCE-BASED INTERVENTION DESIGN (Step 4)

<b>12. Does the intervention address all relevant internal determinants of behaviour?</b>	<ul style="list-style-type: none"> <li>Does the intervention address multiple determinants of behaviour? <ul style="list-style-type: none"> <li>Knowledge, including knowledge of sexual issues, HIV, other STD, and pregnancy (including methods of prevention)</li> <li>Perception of HIV risk</li> <li>Personal values about sex and abstinence</li> <li>Attitudes toward condoms (including perceived barriers to their use)</li> <li>Perception of peer norms about sex and perception of peer sexual behaviour</li> <li>Self-efficacy to refuse sex and to use condoms</li> <li>Intention to abstain from sex or to restrict frequency of sex or number of sexual partners</li> <li>Communication with parents or other adults about sex, condoms or contraception</li> <li>Self-efficacy to avoid STD/HIV risk and risk behaviours</li> <li>Actual avoidance of places and situations that might lead to sex</li> <li>Intention to use a condom</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>Is it based on evidence?</li> <li>What is quality of evidence?</li> </ul>		
	<ul style="list-style-type: none"> <li>Are these objectives directly linked to the intervention activities and materials and are they addressed in intervention materials/ activities?</li> </ul>				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
13. Do facilitators create a safe setting for young people to participate?	· Does the intervention establish group ground rules at its beginning?		· How do you value its quality?		
	· Does the intervention use icebreakers or other activities to ease students into discussion/involvement?				
	· Does the intervention encourage facilitators to provide positive reinforcement when appropriate?				
	· Does the intervention provide tips or recommendations for classroom management?				
	· If needed and appropriate, does the intervention divide students by gender so that they are more comfortable discussing some topics?				
	· Does the intervention provide adequate opportunities for all youth to participate?				
14. Does the intervention provide correct information?	· Is the information provided in the intervention correct? - Medically correct - myths and misconceptions are corrected		· How do you value its quality?		
	· Is the information factual (not value-based)? - Are facts and figures provided? - Do you have factsheets?				
	· Is the information complete (not withholding information)?				
	· Is the information tailored to the target group? - Age - Literacy - Gender				
	· Is the information provided through active learning/ participatory methods (e.g., small group work)?				
	· Do the activities help participants to apply the information to their own lives?				
15. Does the intervention address risk perception?	· Does the intervention inform young people about their chances of contracting STI or HIV and/or becoming pregnant (or getting someone pregnant)?		· How do you value its quality?		
	· Does the intervention clearly inform young people about the negative consequences associated with STIs, HIV and/or unintended pregnancy?				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	<ul style="list-style-type: none"> <li>· Does the intervention include activities that motivate young people to prevent STI, HIV and/or unintended pregnancy?               <ul style="list-style-type: none"> <li>- Information on how to prevent this</li> <li>- Skills building to increase confidence that they can do something about it</li> </ul> </li> <li>· Do the activities encourage young people to actively obtain the risk information? For example,               <ul style="list-style-type: none"> <li>- Quizzes</li> <li>- Small group work</li> </ul> </li> <li>· Do the activities help participants to apply risk information to their own lives?               <ul style="list-style-type: none"> <li>- Activities to assess their personal risk</li> <li>- Activities to become aware of consequences</li> </ul> </li> </ul>				
<b>16. Does the intervention encourage clarification of one's own attitudes, values and social influence?</b>	<ul style="list-style-type: none"> <li>· Does the intervention include activities to clarify people's own values and attitudes?               <ul style="list-style-type: none"> <li>- Does the intervention discuss common situations that might lead to sex and how to avoid these situations?</li> <li>- Does the intervention discuss common situations that might lead to sex?</li> </ul> </li> <li>· Do the intervention activities and materials include persuasive arguments in favour of safe sexual behaviour?               <ul style="list-style-type: none"> <li>- advantages of delay of sexual intercourse and abstinence from sex</li> <li>- advantages of use of condoms when having sexual intercourse</li> <li>- only have consensual sex</li> <li>- are short-term consequences of unprotected sexual intercourse provided?</li> <li>- are individual/ target group values and norms addressed?</li> <li>- are negative consequences of safe behaviour (e.g., of condom use) acknowledged and advantages promoted?</li> </ul> </li> <li>· Does the intervention correct misconceptions about social norms?               <ul style="list-style-type: none"> <li>- Are people provided with factual information to correct misperceptions?</li> </ul> </li> <li>· Are other target groups also encouraged to clarify values, norms and attitudes?               <ul style="list-style-type: none"> <li>- E.g., facilitators, schools, parents, community</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> </ul>		

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
17. Does the intervention include interactive skills training?	<ul style="list-style-type: none"> <li>· Are the following skills trained?               <ol style="list-style-type: none"> <li>1) refuse unwanted, unintended or unprotected sex</li> <li>2) insist on using condoms or contraception</li> <li>3) use condoms correctly</li> <li>4) general assertiveness skills</li> <li>5) obtain condoms or contraception</li> <li>6) obtain STI/HIV testing and treatment</li> </ol> </li> </ul>		<ul style="list-style-type: none"> <li>· Are participants encouraged to train the skills themselves in e.g., role play?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Are the skills trained in role plays following the next steps:               <ul style="list-style-type: none"> <li>- Describe components of the skills verbally</li> <li>- Model them in role plays</li> <li>- Provide individual practice through role plays in groups of two to four</li> <li>- Feedback by facilitator</li> <li>- Starting with easier situations, moving to increasingly difficult situations</li> <li>- Practicing real-life situations</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Does the training of facilitators include skills training?               <ul style="list-style-type: none"> <li>- open communication with young people about sexuality</li> <li>- use an interactive approach in teaching</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· Are participants encouraged to train the skills themselves in e.g., role play?</li> </ul>		
18. Do young people have access to individual support?	<ul style="list-style-type: none"> <li>· Does the organisation provide individual support and counselling if needed?</li> <li>- Is staff trained to provide this?</li> </ul>		<ul style="list-style-type: none"> <li>· Is the support and counselling of good quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Is a referral system to health care providers established?</li> </ul>		<ul style="list-style-type: none"> <li>· Is the system of good quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Does the organisation (or school) have a policy with regulations and facilities related to safety, health, and protection of young people?</li> </ul>		<ul style="list-style-type: none"> <li>· Is the policy implemented?</li> <li>· Is the policy comprehensive?</li> </ul>		
19. Does the intervention promote communication with parents or other adults?	<ul style="list-style-type: none"> <li>· Does the intervention provide students with activities (e.g., home work assignments) that encourage them to communicate with their parents or other adults about a topic related to the program?</li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Does the intervention provide parents or other adults with information about adolescent sexual behaviour, pregnancy, STD, including HIV, in their region, or other relevant               <ul style="list-style-type: none"> <li>- information to help them communicate with their adolescents?</li> </ul> </li> </ul>				
	<ul style="list-style-type: none"> <li>· Do you obtain consent from parents for young people to participate in the intervention?</li> </ul>				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
<b>20. Are the topics in the intervention covered in a logical sequence?</b>	<ul style="list-style-type: none"> <li>· Is the intervention structured in a logical way?</li> <li>· Are the following topics addressed?               <ol style="list-style-type: none"> <li>1. Self-esteem, as basis for learning to make own decisions</li> <li>2. Adolescent development (physical, emotional, psycho-social changes)</li> <li>3. Explanation of rights</li> <li>4. Sexuality, pleasure, intimacy, love and relationships</li> <li>5. Sexual health problems</li> <li>6. Consensual sexuality</li> <li>7. Behaviours to reduce vulnerability, prevention of health risks</li> <li>8. Knowledge, values, attitudes and barriers related to these behaviours</li> <li>9. Skills needed to perform these behaviours</li> <li>10. Support in sexual health problems</li> <li>11. Future plans</li> </ol> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> <li>· Are they followed in this (or other logical) sequence?</li> </ul>		
<b>21. Is the intervention attractive for the target group?</b>	<ul style="list-style-type: none"> <li>· Is the intervention (activities and materials) attractive for young people?               <ul style="list-style-type: none"> <li>- consistent with developmental age, language, cognitive development and literacy levels</li> <li>- attractive form and packaging: clear, vivid, pictures, colours, graphs, appropriate for target group, font &amp; readability</li> </ul> </li> <li>· Did you implement activities to actively recruit and retain youth?               <ul style="list-style-type: none"> <li>- avoid or overcome obstacles to their attendance</li> <li>- assure safety</li> <li>- incentives for attendance</li> <li>- convenient, safe and comfortable location</li> <li>- convenient time for youth</li> </ul> </li> <li>· Is the intervention (activities and materials) attractive and functional for the facilitators?               <ul style="list-style-type: none"> <li>- Reasonable size and weight of materials</li> <li>- resistant and durable</li> <li>- Cost is reasonable</li> <li>- activities are logically described in a facilitators manual</li> <li>- intervention materials are functional</li> <li>-</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> </ul>		

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
<b>22. Is the intervention pre-tested and piloted?</b>	<ul style="list-style-type: none"> <li>Was the intervention pre-tested on the following topics? <ul style="list-style-type: none"> <li>how well they liked individual activities</li> <li>how they interpreted those activities</li> <li>what they got out of activity</li> <li>how the activities could be made better</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>was it pre-tested with young people and facilitators?</li> <li>How do you value its quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>Were modifications and improvements made after the pre-testing?</li> </ul>		<ul style="list-style-type: none"> <li>To what extent can it be possible that the modifications will decrease the impact of the intervention?</li> </ul>		
	<ul style="list-style-type: none"> <li>Was the intervention piloted (full implementation on a small scale)?</li> </ul>		<ul style="list-style-type: none"> <li>How do you value its quality?</li> </ul>		

## F. ADOPTION AND IMPLEMENTATION (Step 5)

<b>23. Did you implement activities to increase adoption of the intervention?</b>	<ul style="list-style-type: none"> <li>Did you organise activities for the following actors in adoption/ acceptance of the intervention? <ul style="list-style-type: none"> <li>Management of organisation/ school</li> <li>Parents and wider community</li> <li>(Intended) facilitators</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>How do you value its quality?</li> </ul>		
<b>24. Is the intervention implemented by appropriate facilitators?</b>	<ul style="list-style-type: none"> <li>Are the selected facilitators meeting the following characteristics: <ul style="list-style-type: none"> <li>Ability to relate to youth and being youth friendly</li> <li>Some experience with SRHR education and comfortable talking about sexuality with young people</li> <li>Motivated to work on SRHR of young people</li> <li>Willingness to promote the rights of young people</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>How do you value its quality?</li> </ul>		
<b>25. Do the facilitators get training and support to implement the intervention as was intended?</b>	<ul style="list-style-type: none"> <li>Are the facilitators trained to implement the intervention? <ul style="list-style-type: none"> <li>(Accredited) training on young people's SRHR</li> <li>Training of interactive teaching skills, participatory didactical techniques</li> <li>Attitude and value clarification of teachers towards sexuality, communication about sexuality</li> <li>Exercising some of the most difficult activities in the intervention</li> <li>Familiar with the content of the intervention</li> <li>Convinced that they have to implement activities according plan</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>How do you value its quality?</li> </ul>		

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
	<ul style="list-style-type: none"> <li>· Are there support procedures in place?</li> <li>- Refresher trainings</li> <li>- Review /feedback meetings</li> <li>- Supervision and monitoring</li> <li>- On the job support and feedback</li> </ul>				
	<ul style="list-style-type: none"> <li>· Is the intervention implemented according plan?</li> <li>- Was the intervention implemented in the setting for which it was designed?</li> <li>- Were nearly all the activities implemented?</li> <li>- Were activities on increasing condom use still included?</li> <li>- Will not implementing these activities compromise the intervention's fidelity and thus compromise effectiveness?</li> </ul>				
<b>26. Do you ensure sustainable implementation?</b>	<ul style="list-style-type: none"> <li>· Do you aim to sustain implementation in a limited number of settings (schools, centres, organisations)?</li> <li>- Did you embed the intervention in the main programme and policy?</li> <li>- Are funds allocated?</li> <li>- Are you able to motivate volunteers?</li> <li>- Are incentives guaranteed (e.g., certificates)?</li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> </ul>		
	<ul style="list-style-type: none"> <li>· Do you aim to upscale the implementation?</li> <li>- Do you plan for obtaining sufficient funding?</li> <li>- Do you attempt to mainstream the intervention in national/ regional/ organisational programmes?</li> <li>- Involvement from start</li> <li>- Lobbying</li> <li>- Adapt intervention to guidelines/ policies</li> </ul>				

## H. MONITORING & EVALUATION (Step 6)

<b>27. Did you evaluate behaviour change?</b>	<ul style="list-style-type: none"> <li>· Are the objectives on the level of determinants evaluated?</li> </ul>		<ul style="list-style-type: none"> <li>· How do you value its quality?</li> <li>- Tools, data collection</li> <li>- Reliability</li> <li>- Qualitative/ Quantitative</li> </ul>		
	<ul style="list-style-type: none"> <li>· On young people's sexual behaviour</li> </ul>				
	<ul style="list-style-type: none"> <li>· On behaviour of facilitators</li> </ul>				
	<ul style="list-style-type: none"> <li>· Other relevant actors</li> </ul>				

CHARACTERISTIC	INDICATORS - WHAT	++ + - -- X	INDICATORS - HOW	++ + - -- X	COMMENTS SUGGESTIONS FOR IMPROVEMENT
28. Do you evaluate and monitor intervention design and implementation processes?	· To what extent did you measure whether the intervention design process meets effectiveness characteristics?		· How do you value its quality? - Tools, data collection - Reliability - Qualitative/ Quantitative		
	· To what extent did you measure whether the content and activities and materials meet effectiveness characteristics?				
	· To what extent did you assess whether all stages of implementation are optimally performed?				

## ANNEX 1. Global evidence

This Annex provides evidence for each of the characteristics in the tool. The evidence is to a large extent based on the reviews of Kirby and colleagues.

### A. APPROACH

The first category of characteristics relates to crosscutting approaches that are used in the planning and content of the intervention.

#### 1. Is the intervention based on a comprehensive approach?

Interventions that are based on a comprehensive approach towards young people's sexual and reproductive health and rights are more likely to address the needs and problems young people face. Comprehensive SRHR interventions are based on the sexual and reproductive rights of young people, include gender, address all behavioural options for young people, embed HIV-prevention in the broader scope of SRHR and adolescent development, and take an enabling environment into account.

##### *Rights based approach*

Comprehensive interventions are based on a rights-based approach.<sup>11</sup> Sexual and reproductive rights of young people include:

- Right to be yourself: free to make your own decision, to express yourself, to enjoy sex, to be safe, to choose to marry (or not to marry) and plan a family

- Right to know: about sex, contraceptives, STIs, HIV/AIDS and reproductive and sexual rights
- Right to protect oneself and be protected by others: from unplanned pregnancies, STIs, HIV/AIDS and sexual abuse
- Right to have access to health services: which is confidential, affordable, good quality and given due respect
- Right to be involved: in planning programs with and for youth, attending meetings/seminars etc. at all levels and trying to influence governments through appropriate means

##### *Gender*

Interventions that include gender in the design and implementation are more effective than interventions that do not. This is underlined by the rights based approach, aiming at equal rights of females/girls and males/boys.<sup>12;13;14</sup> Including gender means that where needed and possible, planners approach males and females in an equal way, both in the content and planning of the intervention: targeting both males and females in interventions, but also involving both males and females in planning the intervention or in implementation.

By equal involvement of both girls/women and boys/men in intervention *design*, planners increase the success of an intervention and its implementation. For instance by involving equal numbers of males and females in advisory groups who are involved in providing feedback on the content and process of the intervention. But also by making sure that both males and females can contribute equally during meetings and are taken serious.

The *content* of the intervention should also address gender issues, particularly taking into account the position and status of girls. Education for girls should emphasise that they are capable, powerful and 'can be in control', both generally and more specifically in regard to resisting unwanted or unprotected sex and insisting on condom use. Education for boys should include empathy and skills to 'replace' themselves in girls and that they should be responsible and respectful to girls.

Gender should also be part of an *organisation's* own policy. A gender policy and organisational culture promotes equity of males and females, may have particular regulations for maternal leave, equal number of male and female staff.

### ***Behavioural messages***

Programs that only address the message of abstinence (including delay) among young people, have not shown any effect in behaviour change, they have only shown effect in changes in attitudes towards abstinence (/delay).<sup>15;16;17</sup> Programs that address both delay and condom use (comprehensive programs) have shown to be effective in the promotion of contraceptive and condom use.<sup>18;19;15</sup> Programs that encourage young people to take their own decisions are most effective, and therefore require correct, complete and non-judgemental information about behavioural options for young people.

### ***Integration of HIV/AIDS prevention in SRHR promotion***

The risk of HIV/AIDS only interventions is that it tends to focus on the risks of unprotected sexual intercourse and is primarily fear-based. When youth hear only about sexuality related to AIDS (negative), they may get a negative view on sexuality as well. By integrating HIV prevention into the broader perspective of adolescent development and a positive approach towards sexuality, the intervention is more likely to be successful.

### ***Enabling environment***

A comprehensive approach also takes into account the environment or context in which young people live and where the intervention is implemented. For example, addressing legislation and policy, health services and counselling, availability of supplies such as condoms.

### **More information**

- IM Toolkit for Planning Sexuality Education Programs; Chapter 3. Young People's Sexual and Reproductive Health and Rights<sup>1</sup>

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them.*<sup>3</sup>

## **2. Does the intervention explicitly communicate about sexuality?**

Effective SRHR interventions are based on explicit communication about sexuality.<sup>2;20;15;21;22;23</sup> Many people think that when they start talking with young people about sexuality and condoms, that this will encourage them to have sex. However, there is a lot of evidence that shows that explicit communication with young people about sexuality and condom use does *not* increase sexual activity among youth, and sometimes even leads to delay of sexual intercourse.

With *explicit* communication we mean that the intervention materials and also the facilitators explicitly name the genitals, explain what is meant with sex, sexuality, sexual intercourse, masturbation, sexual orientation, contraceptives, condoms, etcetera, and takes own decision making into account.

Planners should *tailor* the communication about sexuality to the specific *target group*. For example, they communicate about other topics with primary school children than with secondary school youth. The same holds for a different approach between out of school or in school youth, or urban or rural.

Usually, sexuality education is implemented by *facilitators*, such as youth workers, peer educators or teachers. Explicit communication about sexuality is often difficult for them. Good training and support of facilitators, such as skills training are conditional for them to put this into practice.

The *approach towards young people* in the intervention and by the facilitators is conditional for the success of the intervention. Sexuality should be approached in a positive way, something that can be enjoyed by young people and something that is nice. Young people should be approached as sexual beings, whether they are currently sexually active or not. They should also be approached as able to take their own decisions. The intervention should give them the right information in order for them to choose what they want themselves. And no young person is the same, so they should be approached as a diverse and heterogeneous group.

#### **More information**

- IM Toolkit for Planning Sexuality Education Programs; Chapter 3. Young People's Sexual and Reproductive Health and Rights<sup>1</sup>

## **B. INVOLVEMENT (Step 1)**

Interventions that are developed behind the desk of intervention planners are less likely to be effective than programs that developed in close collaboration with all relevant stakeholders by a team of planners that have the capacities to do so. In Intervention Mapping the people who are involved in planning are referred to as the linkage system.<sup>24</sup> This linkage system consists of the planning team, the target group (young people), the facilitators (implementers) of the intervention, and other relevant stakeholders.

### **3. Are the right people involved in the planning team?**

Interventions that are planned by a team of people with specific expertise on SRHR education for young people are more likely to be effective.<sup>2</sup> Evidence shows that depending on the scope, content and

target group of the intervention, facilitators and implementation context, the team involved in intervention planning should consist of multiple people with different backgrounds.<sup>2;24</sup>

Interventions are preferably planned by a team of specialists collaborating from the start to end. The team includes people with different backgrounds and expertise, especially in the areas of:

- *Project management*
- *Research* (conducting needs assessment/ situation analysis; expertise in behaviour change and determinants; pre-testing; monitoring & evaluation)
- *SRHR of young people* (statistics, youth culture)
- *Behaviour change theories* (determinants, behaviour change)
- *Design of SRHR interventions for young people* (intervention development; materials and activities; elements of effective intervention design; familiarity with culture and values)
- *Implementation of SRHR interventions for young people* (communicating sexuality with young people and community)

Sometimes the expertise is shared by one person, but sometimes different people have to be involved. In many projects, consultants are involved to only do certain tasks. For example, the researcher only does the research but is not involved in other stages of intervention design anymore. Or an intervention designer is involved at the stage of material production. However, involving these various specialists in all planning stages increases the chance that they fully understand the whole planning process, which increases the quality of the intervention and its implementation.

#### **More information**

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum*<sup>3</sup>

- IM Toolkit for Planning Sexuality Education Programs; Chapter 4. Step 1 Involvement<sup>1</sup>

#### 4. Are young people involved in intervention planning?

Interventions that are planned and developed together with the target group (young people) are more likely to be effective.<sup>4</sup> And youth participation is part of young people's rights.<sup>25</sup> One way of involving them is by establishing a working group of approximately 10 young people. This group, representing the target population, is involved from the start of intervention planning.

They can be involved in the following stages:

- Design of the project plan/ proposal
- Respondents in the needs assessment/ situation analysis
- Interpretation of conclusions of the needs assessment/ situation analysis and deciding about the objectives
- Intervention design (including pre-testing)
- Implementation, as peer educators

##### More information

- IM Toolkit for Planning Sexuality Education Programs; Chapter 3. Young People's Sexual and Reproductive Health and Rights<sup>1</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 4. Step 1 Involvement<sup>1</sup>

#### 5. Are facilitators involved in intervention planning?

Interventions that are planned and developed together with the implementers of the intervention are more likely to be effective.<sup>4</sup> The implementers (or facilitators) of sexuality education can vary from

teachers (in school settings), youth peer educators, experts (such as medical personnel) or youth workers.

One way of involving them is by establishing a working group of approximately 10 facilitators. This group, representing the target population, is involved from the start of intervention planning and provides feedback and input at relevant planning stages:

- Design of the project plan/ proposal
- Respondents in the needs assessment/ situation analysis
- Interpretation of conclusions of the needs assessment/ situation analysis and deciding about the objectives
- Intervention design (including pre-testing)
- Implementation, as facilitators
- Up scaling, as trainers of trainers (ToT)

The involvement of facilitators is important to create commitment among facilitators and to be able to plan an intervention that is attractive and useable for the facilitators. The content, activities and instructions should be designed in such a way that the intervention addresses its objectives and is attractive for facilitators to actually implement it.

The selection of the representatives in the working group can be essential for future implementation. These facilitators could possibly be the future trainers of future facilitators in the phase of up scaling the implementation.

##### More information

- IM Toolkit for Planning Sexuality Education Programs; Chapter 4. Step 1 Involvement<sup>1</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## 6. Are relevant decision makers involved in intervention planning?

Interventions that involved relevant stakeholders in intervention planning are more likely to be effective.<sup>2</sup> Their involvement from the start increases the chance that they are committed to the project which may prevent obstacles and resistance in implementation. Buy-in of an intervention is essential to the long-term success of the intervention.

Their support can be obtained by involving and/or informing them from the start of the project. One way of doing this is establishing an advisory board with representatives of the most important stakeholders. The task of this board is to provide feedback and advice to the planning team in relevant stages of intervention planning. Another way of involvement is by embedding the intervention in the policies or programs of relevant stakeholders, for example embedding a sexuality education curriculum in the national guidelines/ policy of the Ministry of Education.

We distinguish three categories of relevant decision makers:

To guarantee the implementation of the intervention, it is often necessary to obtain at least minimal support from appropriate *authorities* such as the Ministry of Education (when implementing in schools), Ministry of Health, and the Ministry of Youth (or a ministry responsible for youth policies and programs).

Another category of stakeholders consist of organizations or individuals that are needed to fully implement the intervention. These include parents and the wider community, community/ religious leaders, and in schools the involvement of the school administration and school board.

A third group of stakeholders are especially important for collaboration during the implementation, *specialists* in SRHR education, and possible (future) funding agencies. These include a national AIDS commission,

Family Planning Association, funding agencies, relevant Non-Governmental Organisations, health service providers, youth based organisations, and other community organisations.

Involving decision makers and other stakeholders may have the risk of getting many people on board each having their own agenda's, slowing down the process. Careful selection of stakeholders is therefore necessary.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 4. Step 1 Involvement<sup>1</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## C. NEEDS ASSESSMENT/ SITUATION ANALYSIS (Step 2)

The second step in Intervention Mapping is a needs assessment/ situation analysis. In a *needs assessment*, planners assess the needs and assets of young people and in the *situation analysis*, the values, resources and capacities of the community are analysed.<sup>4</sup>

## 7. Is the intervention based on a needs assessment?

Interventions that are based on a needs assessment are more likely to be effective.<sup>2</sup> The aim of a needs assessment is to understand young people's needs and their context as understood by them: their needs and

capacities; what is most important to them; from whom, on what and how they would like to be educated about sexuality. Information (evidence) can be collected using different resources, either existing literature and publications or the Internet; or by collecting new information through Focus Group Discussions, interviews, expert meetings or surveys.

Conducting a needs assessment can be done in a very thorough way, but it is also possible to do this in an easier way. When planners have little time and resources, they should put their priorities on collection of epidemiological data on SRHR and on a qualitative assessment of (sexual) behaviours and determinants that influence behaviour of young people. See the Introduction of the tool for an explanation about health, behaviour, environment and determinants.

Topics that can be assessed:

- Overall quality of life of young people
- Magnitude of SRHR problems of young people: HIV/STI rates, Teenage pregnancy, abortion, Sexual abuse/ harassment
- Sexual behaviours of young people: sexual behaviour/ abstinence, Condom use, Number/ kind of sexual partners
- Internal determinants of behaviour: knowledge/ misconceptions, attitude/ values/ beliefs, risk perception, skills/ self-esteem/ self-confidence, solutions for their own problems
- External determinants of behaviour: social influence/ norms, laws/ legislation, availability/ affordability of supplies, other external barriers

Equally important to the content of the assessment is the way the data are collected and analysed. This should be done in an 'objective' way: planners should try to find out what is actually happening, not what they like to see happening. For instance, by only selecting the information that is consistent with their own perceptions and values. Some indicators for the quality of the needs assessment are:

- What is the reliability and quality of data?

- To what extent are data applicable to your target group?
- Were data collected among representatives of the target group?
- Were data collected among multiple adults who are involved with youth?
- Were the data collected by trained researchers/ assistants?
- Were challenges in avoiding sex and using condoms or contraceptives discussed openly?
- Was the methodology of data collection of good quality?
- Was the analysis of data done objectively?
- Was the reporting of the results done objectively?

See Chapter 5 of the Intervention Mapping Toolkit for more information how to conduct a needs assessment. Both on content and methodology the chapter provides background information, for instance, how to conduct a Focus Group Discussion.

#### **More information:**

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 2. Assessed relevant needs and assets of target group*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 5. Step 2 Needs Assessment/ Situation Analysis<sup>1</sup>

## **8. Is the intervention based on a situation analysis?**

Evidence<sup>2;26</sup> indicates that interventions are more effective when existing structures, capacities and resources in the community are assessed and used for the implementation. The aim of the situation analysis is to get an overview of the community in which the intervention is implemented and also link this to the broader (national level) context, such as policies and other interventions that exist for young people.

In the situation analysis it is useful to collect relevant *legislation, laws, policies and regulations* related to young people/ adolescents, and particularly related to their sexual and reproductive health and rights (such as gender, HIV/AIDS, sexual abuse, legal age of marriage, abortion, etcetera). In the analysis, planners also look at the extent to which this is actually implemented.

A second category of information relates to the *values and norms in the community* where the target population (young people) live, including values related to sexuality, position of girls and boys, abstinence, marriage, HIV/AIDS, communication with young people about sexuality, condoms and other contraceptives, sexual orientation, abortion, pregnancy, and the right of young people to take their own decisions.

In addition to the values and norms, planners should collect information about *available resources* in the community. They can map the networks of care, including police units, social workers, and the availability of (youth friendly) health care, services, commodities (condoms and other contraceptives), and counselling. They can also assess to what extent it is possible to collaborate with and/or refer to these organisations during implementation of SRHR education.

Fourthly, planners can analyse the *implementation setting* to have a good idea about the opportunities and barriers in adoption and implementation. When the intervention is implemented in a school setting, planners can assess the willingness of various people in the school (such as school administration and others) to adopt the intervention, and look at their knowledge, misconceptions and attitudes. Other factors to look at include availability of safe and comfortable facility for implementing the intervention (e.g., class room), supplies (video equipment, photocopies, markers, flipchart paper, snacks for youth, pencils, etcetera), trained and available staff, adequate staff time.

And in addition to general information about the implementation setting, planners can conduct an analysis of the (intended) *facilitators of SRHR education*, with a focus on the question what they need to be able to implement the intervention. Planners can look at their behaviour and determinants: what are the reasons why they can or cannot implement sexuality education? What motivates them to do this? In terms of internal determinants (knowledge, attitude, skills) and external determinants (materials, time, social support).

Finally, planners can collect and analyse existing SRHR education interventions (including materials) of other organisations for the particular target group and their lessons learned.

The information in the situation analysis can be obtained through literature reviews, interviews and focus group discussions with various people in the community, including facilitators, other organisations working on young people's SRHR. The quality of information depends on a number of factors, as are outlined in the previous characteristic (needs assessment).

#### **More information**

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space and supplies)*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 5. Step 2 Needs Assessment/ Situation Analysis<sup>1</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## D. OBJECTIVES (Step 3)

Step 3 encourages planners to decide about the objectives of the intervention, based on the information of the needs assessment/ situation analysis (step 2).

### 9. Are the ultimate health goals of the intervention clearly outlined?

With ultimate goals we mean the change planners try to achieve at the end of the program in terms of improved health and quality of life. For most organizations it is difficult to measure the actual change in prevalence of HIV/AIDS, STIs, pregnancy, (unsafe) abortion, stigma and sexual violence as a result of their SRHR education. But it is important to have outlined what the ultimate goals of the intervention are and that these goals are based on evidence.<sup>2;4;5</sup>

Generally the aim of SRHR education is to reduce young people's vulnerability, or to empower them and promote their health and rights. Looking at the health goals, these are different for each particular target group and context. Some examples (of comprehensive SRHR education) include:

- Decrease new HIV infections
- Prevent development of AIDS among people living with HIV
- Increase gender equity
- Decrease prevalence of (young) people facing gender based violence, sexual harassment and abuse
- Decrease new STI infections
- Decrease unintended pregnancy
- Decrease prevalence of (unsafe) abortions
- Decrease discrimination and stigma related to HIV, sexual orientation, gender

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 6. Focused on clear health goals – the prevention of STD/HIV and/or pregnancy*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 6. Step 3 Objectives<sup>1</sup>

### 10. Are the behavioural messages for young people clear and consistent?

Providing clear messages about how young people can behave sexually is one of the most important characteristics of effective SRHR/sexuality education programs.<sup>2</sup> Young people should receive sufficient, correct and consistent information about the options of preventive behaviours, so that they are able to take their own decisions related to their sexual behaviour. In IM, these behavioural messages are referred to as health promoting behaviours.<sup>4</sup>

Clear messages for young people are:<sup>2</sup>

1. Abstinence (from all sexual activities)
2. Only have consensual sex
3. Delay sexual intercourse and practice other sexual activities
4. If you have sexual intercourse, use a condom every time you have sexual intercourse
5. (Serial) monogamy, including an HIV test
6. Limit number of sexual partners
7. HIV and STI testing and treatment

Programs that only address the message of abstinence (including delay) among young people, have not shown any effect in behaviour change, they have only shown effect in changes in attitudes towards abstinence (/delay).<sup>15;16;17</sup> Programs that address both delay and condom use (comprehensive programs) have shown to be effective in the promotion of contraceptive and condom use.<sup>18;19;15</sup>

The behavioural messages are stronger when they are consistent with the information of the needs assessment. For example, whether the appropriate emphases are placed on delaying the initiation of sex, reducing the number of sexual partners or increasing condom or other contraceptive use. This partly depends on the age, sexual experience, family and community values, and culture of the youth for whom the intervention is intended. Linking the behavioural messages with other important values among youth has proven to be effective. For example, by emphasising that avoiding sex or always using a condom is a 'responsible' thing to do, or by stating that youth should only have consensual sex and 'respect themselves'.

Evidence from developing countries indicates that even though behavioural messages are not always clearly outlined in project documents for strategic reasons (to avoid resistance from stakeholders), in implementation, the intervention may still reflect these messages (e.g., because facilitators provide this information to young people).

Evidence also indicates that making behaviours more specific contributes to a better understanding of the risk behaviours and behavioural messages.<sup>4</sup>

In IM this is referred to as *performance objectives*, specific actions that together form the behaviour. For example, the performance objectives for condom use include, young people... 1. Decide to use condoms each time having sexual intercourse; 2. Obtain/ buy condoms, 3. Always take condoms along, 4. Negotiate condom use with sexual partner, 5. Use condoms every time of sexual intercourse, 6. Use condoms correctly and 7. Maintain condom use.<sup>27</sup>

Performance objectives can also be stated for delay onset of sexual intercourse, although there is no (strong) evidence to support this: 1. Decide not to have sexual intercourse, 2. Perform alternative sexual practices (petting, kissing, holding hands), 3. Negotiate with partner safe alternative (non-penetrative) sexual practices, 4. Negotiate with partner on not having sexual intercourse, 5. Avoid risk situations that could lead

to sexual intercourse, 6. Escape risk situations, 7. Maintain abstinence from sexual intercourse.

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them.*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 6. Step 3 Objectives<sup>1</sup>

### 11. Does the intervention address all relevant internal determinants of behaviour?

Evidence<sup>2;6</sup> shows that interventions are more likely to be effective when they address all relevant determinants that influence sexual behaviours, including condom use<sup>28;29</sup> and sexual abstinence.<sup>30;19</sup> This means that the intervention should not only address knowledge/awareness, but should also take into account other determinants, such as beliefs, attitudes, skills, self-confidence, short-term and long-term consequences of unsafe sexual behaviour,<sup>31</sup> and social influence:

- Knowledge, including knowledge of sexual issues, HIV, other STD, and pregnancy (including methods of prevention)
- Perception of HIV risk
- Personal values about sex and abstinence
- Attitudes toward condoms (including perceived barriers to their use)
- Perception of peer norms about sex and perception of peer sexual behaviour
- Self-efficacy to refuse sex and to use condoms
- Intention to abstain from sex or to restrict frequency of sex or number of sexual partners

- Communication with parents or other adults about sex, condoms or contraception
- Self-efficacy to avoid STD/HIV risk and risk behaviours
- Actual avoidance of places and situations that might lead to sex
- Intention to use a condom

To be able to come up with objectives for each of the determinants, planners use the data of the needs assessment where all relevant determinants were assessed. When the evidence is strong and these determinant-objectives are directly linked to the intervention activities and materials, the intervention is very likely to address the actual needs of the target population and more likely to be effective in creating change.

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms and self efficacy)*<sup>3</sup>
- A review was conducted in 2005 of studies investigating determinants of sexual behaviours of young people in developing countries. The review and a summary are available on the Internet.<sup>32</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 6. Step 3 Objectives<sup>1</sup>

## 12. Is it clear what will be done to promote a supportive environment?

Evidence<sup>5</sup> indicates that it is conditional for young people's SRHR to create a safe and supportive environment. The needs assessment/situation analysis provides an overview of the most important environmental barriers and opportunities for addressing young people's SRHR. However, planners cannot do everything and may have to decide to only focus on few interventions and rely on other people or

organisations for other environmental barriers. Some ways to create a supportive environment for young people are described below.

One of the ways of creating a supportive environment is by *awareness raising* in the community and among parents. This may result in more support for young people's SRHR and SRHR/sexuality education of young people. In practice this may lead to more openness for young people to go to the police when they have faced (sexual) abuse, or where other adults report sexual harassment by teachers, or parents are better able to communicate with their children about sexuality.

One of the environmental barriers for young people relate to *health services, supplies* (such as ARVs, condoms and other contraceptives) and *counselling*. These are either not available, or not accessible or affordable. Or the services exist but are not youth friendly.<sup>33</sup> When planners are not able to plan an intervention to provide or improve services, they may decide to set up a referral system to refer youth to other organisations (VCT centres, health clinics, youth centres).

Efforts can be made to *advocate* for the rights and health of young people, and to change relevant policies and laws that are barriers for young people's rights and health. Some websites provide more elaborate information.<sup>34</sup>

When planners decide to also develop interventions in order to address barriers and opportunities in the environment of young people, they can state behavioural objectives and performance objectives for the people who are responsible for these factors. And look at the determinants of these people's behaviours, such as knowledge, attitudes and skills they need to be able to provide services, to change policies or support young people.

#### More information

- IM Toolkit for Planning Sexuality Education Programs; Chapter 6. Step 3 Objectives<sup>1</sup>

## E. EVIDENCE-BASED INTERVENTION DESIGN (Step 4)

Intervention Mapping Step 4, evidence-based intervention design incorporates relevant theories and evidence concerning effective methods, activities and ways of increasing the effectiveness of interventions. Interventions often consist of a number of activities, sometimes provided by facilitators and sometimes through other channels. These activities also often come along with intervention materials and are sometimes documented in workbooks or manuals.

### 13. Do facilitators create a safe setting for young people to participate?

Interventions that create a safe setting for young people when they participate in sexuality education are more likely to be effective.<sup>2</sup> Contributing to a safe setting:

By setting ground rules for group involvement, facilitators contribute to a safe atmosphere. Facilitators can decide to develop these ground rules together with the young people. Some ground rules include \* not expressing put-downs, \* not asking judgemental questions, \* respecting the right to refrain from answering questions, \* recognising that all questions are legitimate questions, \* not interrupting others, \* respecting the opinions of others, and \* views expressed in the group are not communicated outside the group.<sup>35</sup>

Another way of easing the students to contribute in discussions and other activities is by introducing ice-breakers at the start of a session or in between activities where appropriate. Other factors include working with same-sex groups for certain topics or the entire intervention, providing positive recognition and positive reinforcement to young people,<sup>7</sup> provide

tips to facilitators to manage the group, especially when they address sensitive topics.

Other factors relate to the setting and time of participation in the program, such as providing the intervention in a convenient facility or room and at convenient times for youth, and by implementing a school health policy with protection and regulations with regard to interaction between teachers and students and (referral to) friendly youth services and counselling.

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 9. Created a safe social environment for youth to participate*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

### 14. Does the intervention provide correct information?

Providing correct information is conditional for effective interventions.<sup>2</sup> Some factors that contribute to effective provision of information include:

- *Correct* information is provided and myths and misconceptions are corrected; this means that the intervention provides correct information about sensitive topics such as condoms, masturbation or sexual orientation.
- The information is *factual* and not value-based: facts and figures are provided, for example in factsheets indicating from whom the information was obtained
- The information is *complete*, meaning that information (about sensitive topics) is not withheld. The box below provides an overview

of topics related to HIV, STIs and pregnancy that can be addressed in SRHR education programs.

- The (level of) information is *tailored* to the target group, such as age, literacy level, and gender
- The activities help participants to *apply* the information to their own lives
- The information is provided through *active learning* and participatory methods, such as small group work.

Theories<sup>36;37</sup> indicate that active involvement in obtaining information is more effective than passive listening. Examples of interactive teaching methods include short lectures, class discussions, small group work, video presentations, stories, role plays, competitive games, worksheets, homework assignments (e.g., to talk with parents or other youth), drug store visits, clinic visits, question boxes, hotlines, condom demonstrations, and quizzes.

Using participatory methods in a school setting is usually more difficult than in out of school settings. There is often a problem of limited time, teachers find it difficult to handle youth in interactive/ fun approaches and are usually not used to such a way of teaching.

Providing correct information does not only apply to the interventions targeting young people, but obviously also for other groups that are provided with information, such as the facilitators, schools, parents, community and all others participating in any activity in the intervention.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 10. Included multiple activities to change each of the targeted risk and protective factors*<sup>3</sup>
- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors*<sup>3</sup>

### Information topics

(Medically) correct information is provided about risks of having sex and methods of avoiding sex or using protection:

#### HIV/STI

- most common modes of HIV and other STI transmission
- symptoms of STIs
- inability to assess the existence of STIs from a healthy appearance
- susceptibility to STIs
- consequences of STI/HIV (e.g., pain, sterility, ectopic pregnancy, possible death, and effects on newborn infants)
- methods of preventing STIs, including HIV
- common local myths about pregnancy and STIs, including HIV
- effectiveness of abstinence, delay and condom use
- correct use of condoms
- overall knowledge of HIV/STI
- testing and treatment of HIV and other STIs

#### Pregnancy

- causes of pregnancy
- chances of becoming pregnant if sexually active
- consequences of unintended pregnancy
- methods of preventing pregnancy (abstinence, delay intercourse and contraception)
- sources of contraception including community reproductive health resources
- teens' legal rights to contraception
- how different methods work
- effectiveness of different contraceptive methods
- myths and facts about pregnancy and contraception
- refusing and negotiating (consensual and safe) sex
- what to when doubting about and being pregnant

## 15. Does the intervention address risk perception?

Effective interventions address risk communication aiming to increase people's perception of personal risks, both their own susceptibility as well as the severity of the health problems, such as HIV, other STIs and/or pregnancy.<sup>2;38;39;4</sup> Risk communication is only effective when it meets particular conditions:

The intervention informs young people about their *chances (risks)* of contracting STIs, HIV and becoming pregnant (or getting someone pregnant) as a result of unsafe behaviour. This can be done by providing them with prevalence data on youth similar to themselves.

The intervention informs young people about the *negative consequences* associated with STIs, HIV and unintended pregnancy, both short-term and long-term consequences. This can be done by encouraging them to think about how they would feel if they have just heard that they had contracted HIV or another STI, or were pregnant (got someone pregnant).<sup>40</sup> Or through class discussions or videos with true stories of young people having HIV/becoming pregnant who describe the impact of this on their lives.

In addition to the risk information, it is very important that the intervention includes activities and an approach that motivates young people to prevent STI, HIV and/or unintended pregnancy. If this is not done properly, the risk information may lead to fear and even have an adverse effect.<sup>41</sup> It is important that young people are aware of what they can do to prevent SRH problems (e.g., using condoms, not having sexual intercourse) and that they *feel confident* that they can actually do that.<sup>42</sup> Skills building activities are an effective way of increasing confidence.

The intervention is more likely to increase risk awareness when young people *actively obtain* the information and *apply it to themselves*. This can be done by providing interactive activities (e.g., small group work,

quizzes) through which participants assess their personal risk and how HIV, STI and/or unintended pregnancy would affect them.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 10. Included multiple activities to change each of the targeted risk and protective factors*<sup>3</sup>
- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 16. Does the intervention encourage clarification of one's own attitudes, values and social influence?

Interventions that encourage the clarification of one's own values, attitudes and perception of the influence and norms or others are more likely to be effective.<sup>2</sup> Attitudes and norms are some of the factors that determine behaviour that are most difficult to change. It is a long process as people's own values and norms are often embedded within the social context people live. It is difficult to stick to own attitudes when they are different from the people around them.

Evidence and theories provide some suggestions for effective clarification and change of attitudes and perceptions:

*Clarification* of one's own values and attitudes can be encouraged by planners through a variety of activities, such as group discussions about the advantages and disadvantages of for instance having sexual intercourse, or using a condom during sexual intercourse; organising

debates in which people have to defend opposite views on abovementioned topics; or by organising interactive theatre in which the audience is invited to play a role in a theatre play. Another way is by brainstorming with participants about how to avoid or escape situations that may lead to sexual intercourse.

Attitudes can be changed by providing people with *persuasive arguments*.<sup>36</sup> This means that the intervention should use arguments that are in favour of safe sexual behaviours: advantages of delay of sexual intercourse and abstinence from sex, advantages of use of condoms when having sexual intercourse. And it means that the intervention should use arguments that are encouraging young people's rights, such as discussing ways to show someone else you care about him/her, never harass or abuse another, only have consensual sex.

Arguments are more likely to have an effect when short-term consequences (e.g., pregnancy when having unprotected sexual intercourse) are provided than when long-term consequences are provided (e.g., getting AIDS when having unprotected intercourse).

Interventions are also more likely to be persuasive when individual values and norms of participants are addressed, encouraging planners to use interactive learning activities and to use arguments, views and values of the specific target community.

Arguments are also more likely to be persuasive when also the negative consequences are acknowledged. For example, it is possible that people see disadvantages of using a condom during sexual intercourse (difficult and embarrassing to obtain and carry condoms; to talk about sex and condoms with a sexual partner; hassle of using a condom; loss of sensation while using a condom), but the advantages are more important (health, education, future planning).

When planners address *social influence*, they have to be aware of that it has two sides: at one hand the actual influence (community norms, social pressure) and at the other hand the way this is perceived by others. It is difficult to do something about the actual pressure, but people can be trained to deal with this (see the next characteristic about skills). And

planners can correct misperceptions about social norms. For example, young people may think that all other young people have had sexual intercourse before they are 16, but statistics show that this is not correct. Young people can be provided with this factual information to correct misperceptions, using survey data.<sup>7</sup>

The intervention is more likely to change or reinforce attitudes when people *actively obtain* the information and *apply it to themselves*. This can be done by providing interactive activities (e.g., group discussions, quizzes) through which participants assess their own values, norms and perceptions and may see a reason to change these.

Encouraging people to clarify their own values, norms, attitudes and the way they perceive the influence of others does not only apply to the interventions targeting young people, but obviously also for other groups that are provided with information, such as the facilitators, schools, parents, community and all others participating in any activity in the intervention. Especially facilitators such as teachers should become aware of their own perceptions and ideas. It is suggested to start with a session on personal values in a training of facilitators before starting other sessions on SRHR.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 10. Included multiple activities to change each of the targeted risk and protective factors*<sup>3</sup>
- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 17. Does the intervention include interactive skills training?

Skills training is one of the most important components of effective SRHR education.<sup>2</sup> Skills that are most important for young people to acquire include:

- refuse unwanted, unintended or unprotected sex (e.g., exit-strategy for young people who are about to get sexually abused or harassed)
- insist on using condoms or contraception
- use condoms correctly
- general assertiveness skills (coping with social pressure/ norms<sup>7</sup>)
- obtain condoms or contraception; visits with fellow students either to drug stores to locate and price condoms or to clinics to obtain information about obtaining reproductive health services
- obtain STI/HIV testing and treatment

There are different ways to train skills. The most effective method is through skills training (in role plays) following these steps:

1. Describe components of the skills verbally
2. Model them in role plays (by facilitator or by a video or modelling story in printed materials), from easy situations to increasingly difficult situations
3. Provide individual practice through role plays in groups of two to four in which everyone practices, for example, avoiding unwanted sex or insisting on using condoms
4. Feedback by facilitator and/or other young people
5. Starting with easier situations, moving to increasingly difficult situations
6. Practicing in real-life situations (e.g., buying a condom)

Facilitators (and especially teachers) sometimes find it difficult to implement role play activities in a group of young people. Another way of skills building can be done through modelling<sup>39</sup> and/or guided enactment, in for example a video play, role model stories in printed materials. The

desired skills are displayed in role model stories with young people as role models.

Skills building should also be one of the most important activities in the training of facilitators. Important skills for them include open communication with young people about sexuality and to use an interactive approach in teaching.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 10. Included multiple activities to change each of the targeted risk and protective factors*<sup>3</sup>
- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 18. Do young people have access to individual support?

To address the needs of all participating youth in an intervention (and thus being effective), the intervention should include possibilities for individual support.<sup>43</sup> When SRHR education is provided to young people, this may lead to more recognition of individual problems (e.g., related to adolescent development, or to HIV, STIs, pregnancy, sexual abuse and harassment, stigma) and more skills to seek help for this.

Implementing organisations or schools should therefore be prepared to provide individual support, for example counselling. This means that organisations should have trained staff that is able to provide this support in a youth friendly way and if needed is able to refer to more

professional health care providers or counsellors. The organisation should have a referral system in place with names of people in relevant organisations, such as youth centres, health centres, testing centres, counsellors.

The services and the referral system can be part of a health policy, including regulations and facilities within the organisation/school on safety, health and protection of young people('s SRHR).

### More information

· IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 19. Does the intervention promote communication with parents or other adults?

When planners develop interventions for young people, parents and other adults or extend family should be involved. Their involvement may range from very intense to not intense, this depends on the context and openness about sexuality. Sometimes it is necessary to ask consent from the parents for young people to participate in an SRHR promotion intervention.

To increase effectiveness of the intervention, the intervention should promote communication between parents or other adults with the young people.<sup>2</sup>

One way of increasing communication between parents (or other adults) and young people is by provide young people with activities (e.g., home work assignments) that encourage them to communicate with their parents or other trusted adults about a topic related to the program.

This can also be done by providing parents or other adults with information about adolescent sexual behaviour, pregnancy, STIs, including HIV, in their region, or other relevant information to help them communicate with their adolescents.

### More information

· IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 20. Are the topics in the intervention covered in a logical sequence?

Part of a program's effectiveness involves its organization and presentation of activities and materials. In many, but not all, effective school curricula, the determinants and the activities addressing them were presented in an internally logical sequence.<sup>2</sup> Often the interventions first enhance the motivation to avoid HIV, other STD and pregnancy by emphasising susceptibility and severity of these events, then gave a clear message about behaviours to reduce those risks, and, finally, addressed the knowledge, attitudes and skills needed to change those behaviours.

The sequence can be different in different contexts and depends on the content of the intervention. An example of a logic sequence of topics in comprehensive SRHR education:<sup>2;44;45</sup>

1. Self-esteem, as basis for learning to make own decisions (self image, autonomy and decision making)
2. Adolescent development:
  - a. Physical changes (e.g., menstruation, masturbation)
  - b. Emotional changes
  - c. Psycho-social changes (e.g., relations with parents, friends, peers)

3. Explanation of rights to empower young people to take own decisions (gender, culture and religion)
4. Sexuality (sexual practices, sexuality and pleasure, intimacy, love and relationships)
5. Sexual health problems (basic information about HIV, living with AIDS, other STIs, pregnancy, abortion; susceptibility and severity of health problems)
6. Consensual sexuality (sexual harassment and abuse)
7. Behaviours to reduce vulnerability, prevention of health risks (abstinence, delay sexual intercourse, condom use, contraception use)
8. Knowledge, values, attitudes and barriers related to these behaviours
9. Skills needed to perform these behaviours
10. Support in sexual health problems (in own environment, professional support such as counselling, testing, care, references for support)
11. Future plans (ending the intervention in a positive way)

Some comprehensive SRHR interventions specifically address stress management or use of alcohol and drugs.

Usually it is more difficult in settings outside schools to implement a very structured intervention, as young people may drop in and out whenever they like.

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 13. Covered topics in a logical sequence*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 21. Is the intervention attractive for the target group?

An important characteristic of effective interventions is that these are attractive for the specific target group. When the intervention is tailored to the specific target group, the intervention is more likely to be attractive, functional and as a result more effective.<sup>44</sup> In this tool we look at the attractiveness of materials and activities for young people and the attractiveness and functionality of the materials and activities for the facilitators (such as teachers, peer educators, youth workers).

The attractiveness of an intervention for young people depends on a number of factors. One of the factors is that the teaching strategies are consistent with the developmental age and academic skills of the young people who participate, such as language, cognitive development and literacy levels.

Secondly, the form and packaging of the education are attractive:

- The material is attractively presented (clear, vivid, pictures, graphs)
- Content and examples are relevant to the target group

Print materials (brochures, leaflet, workbook):

- Pictures, images, colours, graphs, etc. are appropriate to target group
- Pictures, images, graphs, etc. are not racist, sexist, homophobic, coercive or judgmental; are gender sensitive and are sensitive to values and culture of the target group

- Font & readability is appropriate for the target group

Video materials

- Pictures, colours, setting and role models are attractive to target group

Some interventions, such as those implemented in schools, may have a captive audience and do not need to recruit and retain youth. Other programs do not have a captive audience and must recruit and retain youth. If needed, effective programs implement activities necessary to recruit and retain youth and avoid or overcome obstacles to their attendance. For example, if appropriate, effective programs will obtain

parental notification, provide transportation, implement activities at convenient times, and assure safety. Although this characteristic may be obvious, there are many reported examples in the field in which too few youth chose to participate in voluntary SRHR education programs and, thus, the programs were not effective.<sup>2</sup>

Whether the intervention is attractive for facilitators (in addition to the abovementioned factors) also depends on a number of factors:

- The size and weight of materials are reasonable (to transport, keep privately); printed/ printable space is efficiently used
- The materials are resistant and durable
- Cost is reasonable
- The activities are logically described in a facilitators manual (outlining the objectives, sequence of activities, time needed for each activity, materials needed, tips, background information); e.g., per lesson, or per topic
- The intervention materials are functional

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food or obtained consent)*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>

## 22. Is the intervention pre-tested and piloted?

Interventions (activities and supportive materials) are more likely to be effective when they are pre-tested and piloted.<sup>2,46</sup>

*Pretesting* means that on a small scale, in an informal way, some (most difficult) or all of the activities are practiced and evaluated with some

young people (10-20, representatives) and some facilitators. They provide feedback about what works and what not and whether they like it. If needed, the intervention is adapted according the pilot results and the final intervention materials are produced. The need for pre-testing is strongest when little is known about the target population, and when the content of the intervention is controversial or sensitive.

One of the ‘risks’ of adaptation may be that the modifications will decrease the impact of the intervention. For example, the pre-test shows that facilitators feel uncomfortable to do particular role plays to do skills training, and planners decide to change this into a video with modelled behaviour, it may be possible that this activity will have lesser effect.

*Piloting* means that the whole intervention is completely implemented by the facilitators. For instance in schools, all the lessons and sessions of a SRHR curriculum are implemented throughout the whole school year. Planners (and donor agencies) often tend to start with implementation on a large scale after the final intervention materials are produced. Evidence however shows that piloting the intervention on a relatively small scale (e.g., 3 schools or youth centres) gives a lot of opportunity to closely monitor and evaluate the implementation process and adapt the intervention when needed after that.

#### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 5. Pilot-tested the program*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 7. Step 4 Evidence-Based Intervention Design<sup>1</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## F. ADOPTION AND IMPLEMENTATION (Step 5)

Intervention Mapping Step 5 addresses the *adoption* (by facilitators, organisations) and the *implementation* (actual use of the intervention) of interventions. In other words: what should be done to make sure that the facilitators are willing and able to implement the intervention?

### 23. Do you implement activities to increase adoption of the intervention?

When SRHR education interventions are developed, this does not automatically mean that they will be adopted by the relevant organisations and facilitators that are the intended implementers.<sup>4;47</sup> Based on the situation analysis, planners may decide to implement special adoption activities to overcome barriers for adoption.

One of the adopters in SRHR education in schools is the school management and board. Planners may organise meetings or personal interactions with the decision makers in the school to convince them to adopt the intervention. It is important to assess what are the advantages and disadvantages as seen by these actors to be able to come up with persuasive arguments.

Another important group of adopters may be the parents both for in school and out of school settings. Planners may decide to provide them with information about the intervention through printed materials or meetings.

It may also be important to organise specific activities to convince facilitators that it is important that they adopt the intervention. One of the arguments for them may be the permission of the management (in school or organisation).

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

### 24. Is the intervention implemented by appropriate facilitators?

The selection of facilitators is critical for effective implementation.<sup>2</sup> Some desired characteristics of facilitators that implement SRHR education to young people include:

- Ability to relate to youth and being youth friendly<sup>48</sup>
- Some experience with SRHR education and comfortable talking about sexuality with young people
- Motivation to work on SRHR of young people
- Willingness to promote the rights of young people and to encourage them to take their own decisions about their sexuality

Evidence shows that matching youths' race/ ethnicity or gender with that of the educators does not have a significant impact on behaviour change<sup>49</sup> and that the age of the educators (adult-taught or peer taught sex and HIV education) does not affect effectiveness of the intervention.<sup>50;51;52</sup>

Peer education draws on elements of a number of theories in its assumption that certain members of a given peer group (peer educators) can be influential in eliciting individual behaviour change among their peers.<sup>6;7;53;54;55</sup> Peer education may be an effective way of SRHR education, although there is very little evidence that shows that peer

education is effective. It only works under particular conditions, such as extensive support and training and follow up.

In many settings it is difficult to find facilitators that meet the desired characteristics. Then the training and support of facilitators becomes very important.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision and support*<sup>3</sup>
- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## 25. Do the facilitators get training and support to implement the intervention as is intended?

One of the most important characteristics of effective SRHR education interventions is the training and support of the facilitators who implement the intervention, to enable them to implement the intervention as was intended by the planners.<sup>47;56;57</sup>

Minimal training for facilitators to implement SRHR education include:

- (Accredited) training on young people's SRHR
- Training of interactive teaching skills, participatory didactical techniques
- Attitude and value clarification of teachers towards sexuality, communication about sexuality
- Exercising some of the most difficult activities in the intervention
- Increase confidence of facilitators that they are able to implement the intervention activities

- They become familiar with the content of the intervention and are convinced that they have to implement all activities as planned

One week of training however is often not enough for facilitators to implement the intervention, especially not for facilitators who implement the intervention for the first time. In addition to the training, the facilitators should be supported in other ways as well. For example:

- Refresher trainings
- Review/ feedback meetings; a group of facilitators meets periodically to share their experiences and solve common challenges
- (Individual) supervision and monitoring
- On the job support and feedback

Training and support can increase the chance that facilitators implement the intervention as designed, in the setting for which it was designed. Either failing to implement nearly all the activities as designed or implementing the intervention in a different type of setting (e.g., in school instead of after school) may reduce effectiveness.<sup>2</sup>

Interventions may be less likely to be effective when they are shortened considerably and when activities that focus on increasing condom use are omitted.<sup>2</sup>

Increasing the chance that facilitators implement the intervention according plan can be done by involving them from the start in intervention planning and design of intervention activities and materials.

### More information

- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 15. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support*<sup>3</sup>
- Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs; *Characteristic 17. Implemented virtually all activities with reasonable fidelity*<sup>3</sup>

- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## 26. Do you ensure sustainable implementation?

Most planners aim to implement the intervention in a sustainable way. Sustainability can have different meanings and can be achieved in different ways, depending on the kind of intervention, implementing organisation and context.

Sustainable implementation means that implementation of the intervention can be guaranteed for a longer period of time, either with the very same target group and in the very same implementation setting, or by up scaling the implementation to other settings and target groups.

Some planners aim to sustain implementation in a limited number of settings (e.g., schools, youth centres). This can be done by embedding the intervention within the main programme and policy of the organisation, resulting in particular incentives for the facilitators (e.g., certificates), allocation of funds for the implementation. Sustainable implementation of SRHR interventions often depends on voluntary contributions of organisations and facilitators. There should be sufficient incentives for them to continue participation.

The advantage of small scale implementation is that it can be closely monitored, up scaling often means a certain loss of control and possibly effectiveness of the intervention.

Sustainable implementation often depends on sufficient funding to maintain facilitators to implement the intervention and produce materials. Funding can also be obtained from donor organisations.

Another way is by making attempts to mainstream the intervention in national/ regional/ organisational interventions on SRHR education also

by involving them from the start of intervention planning, by adapting the intervention scope and content to the requirements and guidelines of the organisation or government, and by lobbying for inclusion of the intervention in the mainstream programmes.

### More information

- IM Toolkit for Planning Sexuality Education Programs; Chapter 8. Step 5 Adoption and Implementation<sup>1</sup>

## G. MONITORING & EVALUATION (Step 6)

The final step in intervention planning is Monitoring and Evaluation. The two characteristics contributing to the effectiveness of SRHR education are an outcome evaluation and a process evaluation. In an *outcome evaluation* planners measure change among the target population and with *process evaluation* they evaluate the process of development and implementation. Process evaluation relates to monitoring.

## 27. Do you evaluate behaviour change?

In SRHR education one of the challenges is to measure the changes that are created as a result of the intervention. As a small organisation, it is hardly possible to measure whether the intervention has improved health (such as HIV- or STI infections, teenage pregnancy). This is usually done in large-scale research. And if particular health problems are decreasing it is still difficult to identify the exact attribution of the intervention on this outcome.<sup>4</sup>

However, when the intervention is planned in a structured way, it can be predicted whether the intervention will have an effect on people's

health. When the needs assessment is of good quality, identifying the behavioural and environmental factors that influence health, and also the determinants, AND when these needs are sufficiently addressed in the intervention, there is a higher chance that there will be a change in people's behaviour.

Measuring behaviour change is also quite difficult, especially with little resources. One of the ways this can be done is by measuring change in determinants of behaviour. Conducting such a study requires resources (time, funding, expertise).

Ideally, such an evaluation is done with intervention and control groups, that are randomised (randomised controlled trial); is done with sufficient numbers of young people as recipients, to be able to come up with significant data.

#### **More information**

- IM Toolkit for Planning Sexuality Education Programs; Chapter 9. Step 6 Monitoring and Evaluation<sup>1</sup>

## **28. Do you evaluate and monitor intervention design and implementation processes?**

The aim of *process evaluation* is to assess whether the intervention is implemented complete and adequately according plan, and how the users and target group have experienced the intervention.<sup>4</sup> Conducting process evaluation may provide valuable information that can be used to improve implementation which may result in more effectiveness.

Process evaluation can be conducted addressing the following categories of information:

- Design; extent to which the design process meets effectiveness characteristics

- Content; extent to which content of the intervention meets effectiveness characteristics
- Implementation; assess whether all stages of implementation are optimally performed
  - Number of young people that completed the whole intervention & reasons for drop-out
  - Training of facilitators
  - Actual implementation of the intervention activities by facilitators (did they implement all activities as designed, why not?)

Methods of data collection in the process evaluation can include lesson evaluation forms, focus group discussions with young people, facilitators and other relevant actors, questionnaire to measure impact of training and support of facilitators.

#### **More information**

- IM Toolkit for Planning Sexuality Education Programs; Chapter 9. Step 6 Monitoring and Evaluation<sup>1</sup>

## REFERENCES

- <sup>1</sup> Leerlooijer, J.N., Reinders, J. & Schaalma, H.P. (July 2008). *IM Toolkit for Planning Sexuality Education Programs; Using Intervention Mapping in Planning School-Based Sexual and Reproductive Health and Rights (SRHR) Education Programs*. Utrecht, the Netherlands: World Population Foundation.
- <sup>2</sup> Kirby, D., Laris, B.A., & Roller, L. (2006). *The Impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors Among Young Adults*. Research Triangle Park, NC: Family Health International.
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